Project Connect
Detroit Case Study

Project Overview

The Michigan Public Health Institute (MPHI) reached out to school staff at three schools to implement the Project Connect Health Systems Intervention (Project Connect) in an area of Detroit, Michigan with high rates of chlamydia, gonorrhea, and teen pregnancy among youth.

MPHI took processes from the original implementation of Project Connect in Los Angeles and adapted them to fit the on-the-ground assessment of the situation in Detroit. They focused activities on three schools — one with a school-based health center (SBHC), one with a school nurse, but no SBHC, and one without either a school nurse or SBHC. Almost immediately, it became clear that a number of modifications had to be made to the steps used to develop the intervention in Los Angeles. Importantly, MPHI had to identify alternative methods for identifying high-quality providers, had to deal with a markedly different policy context, and had to weather the ups and downs of a school system in distress.

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Context and Setting

Detroit has the highest rates of chlamydia in the state for 15 to 19-year-olds, and nearly half of the state's morbidity for gonorrhea among 15 to 19-year-olds. The city has a teen pregnancy rate almost double that of the state of Michigan. Roughly half of the city's children live below the poverty level and 80% of students receive free or reduced-priced school lunches. Detroit has one of the lowest graduation rates of any large city in the U.S. The recent economic recession has taken a significant toll on Detroit's population and infrastructure.

Implementing Core Components

Environmental Scan

Experience

MPHI partnered with the Michigan Department of Community Health (MDCH) to look at rates of chlamydia and gonorrhea among 15 to 19-year-olds in Detroit at the zip-code level. Possible intervention schools were then identified within or nearby those zip codes with the highest burden of these STDs. Partnership with the Detroit Public Schools (DPS) system and a local health system which provided services within many of the affiliated school-based health centers narrowed this list of possible intervention schools to those most in need and most likely to partner with MPHI to implement Project Connect. Once these schools were selected, MPHI identified individuals within the schools to act as key contacts for ongoing communication and collaboration with school administration and staff.

Lessons Learned

MPHI found that frequent interaction with the key administrative and nursing contacts identified at the schools was quite useful to discuss the implementation, training, and evaluation of Project Connect. They were crucial to the relationship with the schools, as they had a rapport with staff and students that allowed them to promote the project and gain support and participation.

Health care Infrastructure Scan

Experience

To develop their initial provider pool, Los Angeles partnered with the local health department to identify providers in a school's catchment area who had reported 10 or more cases of chlamydia among 15 to 19-year-olds in the past year. In Detroit, the local health department was in the midst of a major transition, so this method could not be used. Instead, MPHI partnered with Michigan Department of Community Health at the state level to identify providers within the area of the three identified schools who reported high burdens of chlamydia and gonorrhea. When that approach was tried, the process did not achieve adequate results. Case reports were scattered; for many cases, a provider was not named in the case reports, so there was no way to tell which provider had reported that case of chlamydia or gonorrhea. One provider had reported more than 30 cases of chlamydia in the past year, which seemed promising; follow-up revealed that the provider had been screening in the juvenile detention center. With the country in the midst of an economic recession, many of the other private providers on

the list had closed their offices within the past year. As an alternative, MPHI compiled a list of all practices in the region that provided care in the following specialties: family planning, obstetrics-gynecology, internists, and pediatricians. The intent was to narrow down this list by administering a provider questionnaire to identified providers of sexual and reproductive health care for youth. However, it quickly became apparent that this was not going to be helpful in finding good community providers. And so, unfortunately, even though they now had two rather long lists, neither of these lists was able to help MPHI generate the kind of referral list needed to be true to the intent of Project Connect.

Ultimately, MPHI used networking with school nurses, SBHC staff, and public health practitioners to develop a baseline list of providers who might be providing high-quality care. From these conversations, they developed a list of providers who were doing a good job of providing sexual and reproductive health care to youth according to these sources. This list contained 25 locations, primarily comprised of public health clinics, community health clinics, free clinics, and hospital clinics. MPHI interviewed this list of providers to collect information on their services, to verify that they were youth-friendly, and to make sure that they were screening and treating youth for chlamydia and gonorrhea.

Lessons Learned

MPHI said that one of the biggest lessons they learned through this process was that, when it came to characterizing the local health care infrastructure for providing sexual and reproductive health care to youth, information was very fractured. In Detroit, at least, it did not rest solely within the health department. One of the staffers at MPHI said, "There are people in the community who are interested in sexual health and they do the best they can with the resources they know, but it's limiting. Everything is so fractured that it's difficult to pull it all together."

During the process of conducting the infrastructure scan, MPHI learned that some small privately-owned medical practices identified in the initial pool of providers were no longer in business. There were also limited options available for Detroit teens searching for STD-related care. Some of the most qualified locations were not in close proximity to the neighborhoods with the highest need, and had limited public transportation accessibility. In addition, very few locations offered evening or weekend hours that could accommodate a youth's school schedule.

Considerations for You

The methods used to identify the initial pool of health care providers in Los Angeles were designed to identify providers thought to see a high volume of youth, to regularly screen and treat youth for chlamydia, and to comply with reporting requirements. Although this structured method should be attempted first, the experience in Detroit highlights the need for flexibility in assessing the local health care infrastructure. The density of your local health care provider network will play a key role. In areas with a high volume of youth-serving providers, health department data may be sufficient to net a large pool of providers which you

can then narrow down. In areas where the provider network is sparser, this may not be sufficient. The key thing to remember is that the goal of Project Connect is not simply to identify every youth-serving provider in the area. Instead, it is to systematically identify those providers who are already doing a good job of providing sexual and reproductive health care to youth.

Development

Experience

Initially, MPHI created a provider referral guide for each school based upon the information gathered from the health care infrastructure scan, key informant interviews, and discussions with school key contacts. The first version included 13 health centers, and provided information about each health center, including contact information, hours of operation, services, payment options, bus line accessibility, and distance from the school. Feedback from students prompted MPHI staff to revise descriptions of some services from medically technical terminology to user-friendly terms more easily understood by the youth. For example, urine-based testing for chlamydia was relabeled as pain-free testing, based on students' feedback.

Key informant interviews with staff at selected health centers were used to verify health center information, such as hours of operation, the availability of special sexual and reproductive health care services, and the availability of general health care services. The youth friendliness of a clinic was assessed by observation of the friendliness of health center staff, availability of youth-friendly materials, accessibility of the health center, and non-intimidating waiting and exam rooms. In almost all cases, distance from the school to the health centers included on the provider referral guide was limited to 20 miles and/or travel time of less than one hour by public transportation. After reviewing all of the information collected, the final revised provider referral guide included seven health centers, three school-based health centers, two school-linked health centers, one city health department clinic, and one mobile health clinic. It is important to note that many students indicated a need for more general health services, in addition to sexual and reproductive health care services, prompting inclusion of this information on the provider referral guide.

MPHI developed poster and hand-out versions of the provider referral guide. Posters with detailed information were distributed to school health center staff, while posters with a more simplified message were displayed in other areas of the school. In addition, a pocket guide version of the provider referral guide was developed. The pocket guide resembled a mini-booklet, contained all of the clinic information appearing on the original provider referral guide, and was designed to be more durable and able to easily slip into a pocket, wallet, or purse.

Lessons Learned

The initial site visits to private providers and community health centers identified gaps in service availability. Some providers accepted only certain Medicaid Managed Care plans, limiting access to some youth. Furthermore, while it is Michigan law that adolescents can receive confidential services regardless of parental consent, there was a clear disconnect between office management and practice staff. Administration indicated that the providers would see a youth without a parent present for sexual and reproductive health services, while front office staff responsible for greeting and scheduling appointments indicated youth would not be seen without a parent. In response, eligibility for inclusion on the provider referral guide was expanded to include the provision of services without parental consent and the acceptance of patients, regardless of insurance type, alongside original eligibility requirements more focused on the availability of key sexual and reproductive health care services. This resulted in the elimination of the federally-qualified health centers, where this divide persisted most strongly.

School staff felt the provider referral guide needed to be better advertised. Advertising beyond distribution of pocket referral guides and posters displayed in school health clinics and school hallways will likely be necessary to maximize youths' awareness of Project Connect resources.

Dissemination and Training

Experience

MPHI staff held Project Connect trainings for each school, covering three primary goals:

- To familiarize staff with Project Connect, Project Connect clinics, and services available at those clinics;
- To offer tips on talking with adolescents about sexual and reproductive health; and,
- To provide background information on Michigan minor consent laws for confidential services.

These trainings were attended by key touchpoints (staff which were trusted sources of information for students)—nurses, counselors, social workers, coaches, and select teachers—and each staff member received a training binder as well as Project Connect provider guides to distribute to students. These trainings were generally held during teacher in-service days, prior to the beginning of the academic year, making it easier to reach a large group of key touchpoints.

After incorporating feedback from staff who participated in pilot program trainings, MPHI developed a Project Connect training binder. This binder included a program overview, a copy of the provider referral guide, annotated clinic information (types of services provided at each clinic location), a checklist of key points for discussion with students, Michigan minor consent and confidentiality information, a glossary of terms, and additional resources. In later years of implementation, MPHI developed a phone app which could be used to train key touchpoints and others critical to the implementation of Project Connect.

Implementing Core Components
Continued...

Lessons Learned

School staff reported some challenges in fully implementing Project Connect in Detroit. The majority of these challenges were the result of feelings by some staff that they were already being overburdened by their various responsibilities. Existing administrative challenges for school staff included poor attendance records at school by some students, insufficient academic progress in school by some students, and a general lack of family involvement in student's lives. At the Project Connect school with an SBHC, SBHC staff reported that they distributed the provider referral guide only when a student needed health services that the health center could not provide, such as contraception. This restricted referral policy was done primarily to keep students coming back to their own clinic.

Difficulties or Obstacles Encountered

All of the schools in Detroit which Project Connect served underwent significant changes during the lifespan of the project. DPS officials regularly terminated thousands of teaching staff at the end of each school year, forcing those teachers to reapply for their positions for the upcoming school year. School nursing staff was eliminated at one project school; one intervention high school was closed and combined with another school. As a result of these and other changes the training and retraining of staff on the purpose and implementation of Project Connect took considerable time and effort. Likewise, the loss of key contacts at certain project schools necessitated constantly rebuilding goodwill and understanding among project school leadership.

Lessons Learned
(Comments from the Site)

MPHI staff felt it was important to build flexibility into the planning and implementation phases of Project Connect. Project implementation in the Detroit project fell behind schedule due to unexpected delays and unforeseen problems, such as problems conducting the health care infrastructure scan, DPS teacher layoffs, school mergers, and the necessity for continual retraining of teachers.

Staff used data collected from key informant interviews with students and SBHC staff to learn that the program needed more effective marketing to students. They decided to rebrand the posters and to develop new and more youth-friendly materials to attract students' attention. Through the rebranding process, new posters, a pocket guide, and a phone app were developed. The QR code was added to all Project Connect marketing materials so that students and/or parents who had smart phones could scan the code and go directly to the app.

Successful, long-term partnerships were developed and maintained with school-based health center staff, and many other community-based organizations. Two schools continued to use the referral guide and pocket guide. The guides were developed and tailored by schools, could be easily updated each year, and could be printed at a local printer. The guides were discovered to be a useful mechanism for disseminating information about contraception, because Michigan law prohibits the direct distribution of contraception materials.

Conclusion

The implementation of Project Connect in Detroit highlighted the need for flexibility and innovation in adapting to local conditions, while staying true to the core tenet of Project Connect, which is linking youth to community health care providers who are already doing a good job of providing sexual and reproductive health care services. When Project Connect in Detroit is compared to Project Connect in Los Angeles, it can be seen that each project presents a new set of challenges. In the Detroit project MPHI was challenged by a constrained and depleted health care infrastructure, an awareness of the increased importance of having flexibility with payment options and insurance acceptability, provider awareness of state laws regulating minor consent and confidentiality, and a school system coping with a variety of shortfalls and an ever-shifting staff of project personnel. Despite these challenges, however, MPHI was able to identify high-quality providers, make key linkages within schools, and deliver information about needed sexual and reproductive health care services into the hands of at-risk youths.